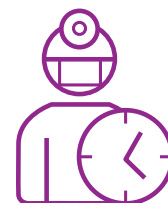


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REPORT CARD ON
ACCESS TO
**OBESITY
TREATMENT
FOR ADULTS
IN CANADA**
2017



REPORT CARD ON ACCESS TO OBESITY TREATMENT FOR ADULTS IN CANADA 2017

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A man and a woman are standing on a wooden pier with a metal railing. The man is wearing a black short-sleeved button-down shirt, black trousers, and sunglasses. The woman is wearing a red and black patterned top. They are both looking towards the camera. In the background, there is a body of water and a clear blue sky.

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WHO ARE WE?

The Canadian Obesity Network-Réseau canadien en obésité (CON-RCO) is Canada's authoritative voice on evidence-based approaches for obesity prevention, treatment and policy. Currently, the network has more than 13,000 professional members and over 2,000 public supporters, over 12,000 followers on Facebook and over 5,000 Twitter followers. Our mission is to improve the lives of Canadians affected by obesity through the advancement of anti-discrimination, prevention and treatment efforts. Our goals are to address the social stigma associated with obesity, change the way policy makers and health professionals approach it and improve access to evidence-based prevention and treatment resources.

FIND OUT MORE AT

obesitynetwork.ca



@CanObesityNet



facebook.com/CONRCO

Detailed information on study methodology and results – including ancillary findings that are not highlighted in this report – are available in the Appendix document.

INTRODUCTION

Obesity is a progressive chronic condition, similar to diabetes or high blood pressure, which is characterized by abnormal or excessive fat accumulation that may impair health.¹ Population health studies measure the prevalence of obesity using a crude measure called the Body Mass Index (BMI). Although this measure is helpful for population health surveillance, it is not a tool that can be used to clinically diagnose people with obesity. Obesity should be diagnosed by a qualified health professional using additional clinical tests and measures.* Based on existing population surveillance studies, the prevalence of obesity in Canada has increased significantly over the past three decades. According to the 2014 Canadian Community Health Survey,² over 5.3 million adults have obesity and according to the 2015 Canadian Health Measures Survey,³ 28.1% or **more than one in four adults in Canada has obesity** and may require medical support to manage their disease.

As a leading cause of type 2 diabetes, high blood pressure, heart disease, stroke, arthritis, cancer and other important health problems, obesity can have serious impacts on those who live with it. It is estimated that one in 10 premature deaths among Canadian adults age 20 to 64 is directly attributable to obesity.⁴ Beyond its effects on overall health and well-being, obesity also affects peoples' overall social and economic well-being due to the pervasive social stigma associated with it. As common as other forms of discrimination – including racism – weight bias and stigma can increase morbidity^{5, 6} and mortality.⁷ Obesity stigma translates into significant inequities in access to employment, healthcare and education, often due to widespread negative stereotypes that persons with obesity are lazy, unmotivated or lacking in self-discipline.⁸

More than one in four adults in Canada has obesity.

Number of Adults^a in Canada with Class I, II & III Obesity in 2014

CLASS I (BMI: 30.00 kg/m²–34.99 kg/m²)

3,758,100

CLASS II (BMI: 35.00 kg/m²–39.99 kg/m²)

1,070,200

CLASS III (BMI: ≥ 40.00 kg/m²)

497,300



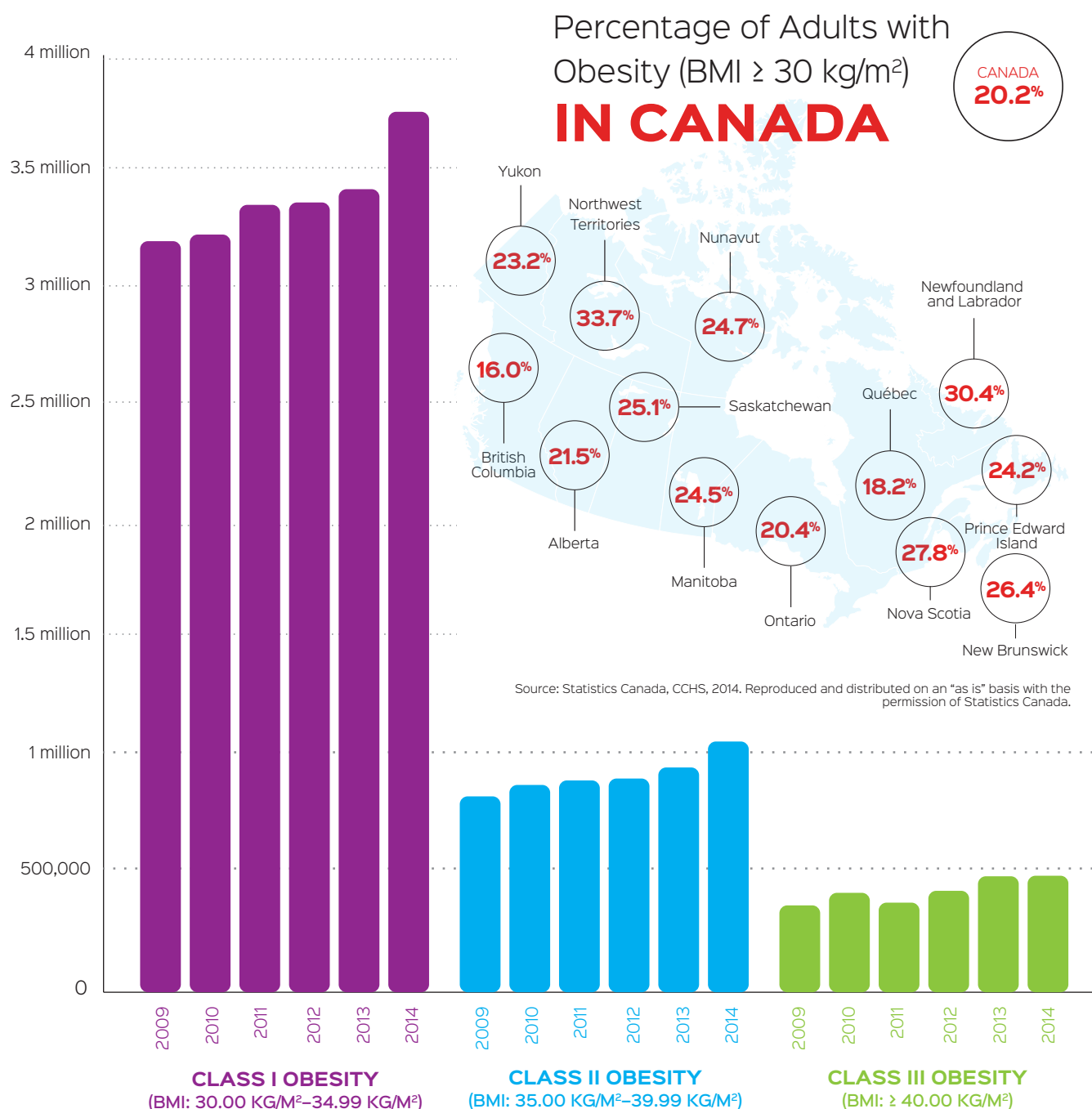
Source: Statistics Canada, Canadian Community Health Survey (CCHS), 2014. Reproduced and distributed on an "as is" basis with the permission of Statistics Canada.
Footnotes:

^a Respondents aged 18 and over excluding pregnant women.

* The Canadian Obesity Network-Réseau canadien en obésité has developed tools and resources to support primary care professionals to conduct evidence-based assessment and diagnosis of obesity. 5As of Obesity Management: www.obesitynetwork.ca/5As

INTRODUCTION

Number of Adults^a in Canada with **CLASS I, II & III OBESITY**



Source: Statistics Canada, CCHS, 2009–2014. Reproduced and distributed on an "as is" basis with the permission of Statistics Canada.

Footnotes:

^a Respondents aged 18 and over excluding pregnant women.

INTRODUCTION

In 2006, the Canadian Clinical Practice Guidelines on the Management and Prevention of Obesity in Adults and Children⁹ (the Canadian Clinical Practice Guidelines) were released to assist physicians and health professionals with supporting patients with obesity. Many organizations – including CON-RCO, the Canadian Medical Association, the American Medical Association and the World Health Organization – have since also declared obesity to be a chronic disease.

Recognizing obesity as a chronic disease is more than a symbolic gesture. It confirms the need to shift away from considering obesity to be merely the result of poor lifestyle choices toward a socio-ecological model of health that carries with it an obligation to our health systems and society to prevent and treat it as we do other chronic diseases.



INTRODUCTION

In 2016, the 10th anniversary of the release of the **Canadian Clinical Practice Guidelines**,⁹ CON-RCO sought to quantify and qualify access to publicly provided medical care for obesity, as well as interventions covered by private health benefit plans. ***Report Card on Access to Obesity Treatment for Adults in Canada 2017*** is the result of nearly a year of detailed research.

Can obesity be treated?

Like many other chronic conditions, obesity is treatable. The Canadian Clinical Practice Guidelines⁹ recommended the application of the following interventions for adults who have obesity: lifestyle intervention (dietary intervention, physical exercise therapy and cognitive behaviour therapy), pharmacotherapy and bariatric surgery.

The substantial impact of treating obesity in controlling and, in some cases, improving a broad range of clinical conditions, including osteoarthritis, diabetes, sleep apnea, hypertension, urinary incontinence and even infertility, has also been well demonstrated in recent research.¹⁶



METHODOLOGY



The scope of this report was limited to services available in the publicly funded healthcare system. Publicly accessible resources and documents were researched extensively for evidence of policies, guidelines and services for obesity treatment and management in each province and territory. CON-RCO also conducted a thorough review of scientific literature on the access to obesity treatment and management in Canada. The areas of inquiry for this report were inspired by the Canadian Clinical Practice Guidelines,⁹ with a focus on public access to the following obesity treatment and management options for adults:



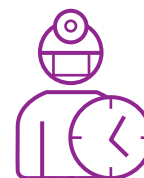
Access to specialists and interdisciplinary teams for behavioural intervention



Access to medically supervised weight-management programs with meal replacements



Access to anti-obesity medications* through public and private means



Access to bariatric surgery and wait times

Survey instruments were also designed to acquire information on provincial and territorial policies and services, private drug benefit plans offered by the health insurance industry and bariatric surgical services and wait times. Industry experts and a Scientific Working Group comprised of health researchers with expertise in obesity reviewed the data collection framework and survey instruments. Interviews based on the survey instruments were conducted with representatives of health insurance companies, healthcare staff in bariatric surgical centres and representatives of provincial and territorial governments or health service authorities.

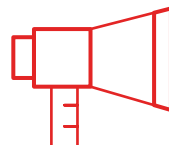
Data on the number of persons with obesity, the number of bariatric surgeries and coverage rates in private drug benefit plans for anti-obesity medications were acquired from Statistics Canada, Canadian Institute for Health Information (CIHI) and TELUS Health Analytics, respectively. Data collection occurred between August 1, 2016, and December 31, 2016.

* The term anti-obesity medication is the standard language used in chronic disease management frameworks. This term does not imply actions against people with obesity.

How easily available was this information?

- 1** The search for information on the recognition of obesity as a chronic disease and treatment guidelines or recommendations by provincial/territorial governments and identifying appropriate policy makers in each province/territory required significant effort. Many provinces and territories do not have a person or department dedicated to the bariatric or obesity-treatment portfolio. This also could be because the efforts of some provincial/territorial governments are focused on obesity prevention and health promotion for children, youth and families.
- 2** The search for information on interdisciplinary teams for obesity management and weight-management programs with meal replacements also required significant effort. Some provinces, like Alberta and Ontario, offer a list of centres.
- 3** Information on medications in the provincial/territorial formularies and American Board of Obesity Medicine (ABOM) physicians in each province/territory was easily available through publicly accessible databases.
- 4** Information on coverage rates of anti-obesity medications in private drug benefit plans was acquired with significant difficulties. Data also needed to be acquired from TELUS Health Analytics.
- 5** Information on bariatric surgical centres, the services provided in these centres and wait times were available with some effort and were acquired via personal communications with each centre.
- 6** Only British Columbia, Québec and Nova Scotia make information on wait times for bariatric surgery and the number of persons on the waiting list available publicly.

RECOGNITION OF OBESITY AS A CHRONIC DISEASE AND PUBLIC POLICY



In October 2015, the Canadian Medical Association declared obesity to be “a chronic medical disease requiring enhanced research, treatment and prevention efforts.”¹⁷

The declaration was praised by people living with obesity as well as healthcare and academic professionals, who supported that recognition of obesity as a disease may help precipitate a shift in thinking of obesity as just a lifestyle choice to a medical disease with an obligation to prevent and treat it as other chronic diseases. There also was a call to continue to advocate for public policy, education and awareness to address weight discrimination in Canada.



- ➡ Since the declaration, none of the provincial or territorial governments have officially recognized obesity as a chronic disease.
- ➡ Health Canada has also not officially recognized obesity as a chronic disease and has continued to consider obesity as a lifestyle risk factor. There is no directive from Health Canada on the treatment and management of obesity in adults.
- ➡ A 2016 report¹⁸ of the Senate Standing Committee on Social Affairs, Science and Technology titled *Obesity in Canada*, referred to obesity as a risk factor for several chronic conditions.
 - Twenty-one recommendations were made in this 2016 report, and most of these revolved around obesity prevention and health promotion. Among the recommendations were a call for a national campaign to combat obesity, a complete revision of Canada’s Food Guide, a ban on advertising food and drink to children, a possible tax on sugar-sweetened beverages, a review of nutrition food labelling and a plan for making healthy food more affordable. Out of the 21 recommendations in this report, none were direct recommendations for access to obesity management or treatment or to bariatric care.
 - The report did not refer to the Canadian Clinical Practice Guidelines.⁹



- The report did not include a recommendation to address weight bias and weight discrimination, and there is no evidence that Canadians affected by obesity were engaged in the development of these recommendations.
- Since the report, Health Canada has launched initiatives to address obesity in the pediatric population and for obesity prevention¹⁹ and has started a process to revise Canada's Food Guide.²⁰
- Prescription of exercise and physical activity by physicians and the inclusion of qualified exercise professionals in the health-care teams was also recommended in the report.

➔ Person-first language is often not used in the resources produced by the federal, provincial and territorial governments.

KEY MESSAGE

The lack of recognition of obesity as a chronic disease has a significant impact for adults in Canada.

Some provincial governments have focused their attention on health promotion among children and families and have not implemented obesity-treatment programs for adults affected by obesity. Canadians affected by obesity are left to navigate a complex landscape of weight-loss products and services, many of which lack scientific rationale and openly promote unrealistic and unsustainable weight-loss goals. Failure rates of over 95% perpetuate a vicious cycle of “yo-yo dieting,” resulting in frustration, depression, poor self-esteem and further weight gain.²¹

A snapshot of policies and services in each of the provinces and territories is available in the Appendix document.

ACCESS TO BEHAVIOURAL INTERVENTIONS AND INTERDISCIPLINARY TEAMS FOR OBESITY MANAGEMENT



The Canadian Clinical Practice Guidelines⁹ recommend a comprehensive healthy lifestyle intervention for adults who are living with obesity (a combination of behaviour modification techniques, cognitive behavioural therapy, activity enhancement and dietary counselling) and that primary health professionals work with other healthcare providers to develop comprehensive weight-management programs for adults with overweight or obesity to promote and maintain weight loss.

A recent systematic review²² of obesity management in primary care showed that improvements in clinically relevant health outcomes could be achieved by multi-component weight-management interventions that are delivered over a longer term by an interdisciplinary health team. There also is evidence that medically supervised programs that have an interdisciplinary team component increase the likelihood of meaningful weight management. Reports from Canadian clinics with an interdisciplinary approach to obesity management demonstrated that almost half of the patients had attained clinically significant weight reductions^{23, 24} in as little as six months.²⁵

For the purposes of the *Report Card on Access to Obesity Treatment for Adults in Canada 2017*, an interdisciplinary team for obesity management was defined as any team composed of some combination of a physician, dietitian, nurse/nurse practitioner, exercise therapist/kinesiologist, social worker and/or psychological counsellor working together with the goal of providing weight management/obesity management for adults in the community.

ACCESS TO BEHAVIOURAL INTERVENTIONS AND INTERDISCIPLINARY TEAMS FOR OBESITY MANAGEMENT



- ➡ Among the health services provided at the primary care level for obesity management, dietitian services are most commonly available to Canadians with obesity.
- ➡ Access to exercise professionals, such as exercise physiologists and kinesiologists, at the primary care level is limited throughout Canada.
- ➡ Access to mental health support and cognitive behavioural therapy for obesity management at the primary care level is also limited throughout Canada. Bariatric surgery programs often have a psychologist or a social worker that offers mental health support and cognitive behavioural therapy to patients on the bariatric surgery route, but the availability of these supports outside of these programs is scarce.
- ➡ Centres where bariatric surgery is conducted also have interdisciplinary teams that work within the bariatric surgical programs and provide support for patients on the surgical route.
- ➡ Alberta and Ontario have provincial programs with dedicated bariatric specialty clinics that offer physician-supervised medical programs with interdisciplinary teams for obesity management.
- ➡ Interdisciplinary teams for obesity management outside of the bariatric surgical programs are available in one out of five regional health authorities (RHA) in British Columbia, one out of 18 RHAs in Québec, one out of two RHAs in New Brunswick and one out of four RHAs in Newfoundland and Labrador.
- ➡ Among the territories, only Yukon has a program with an interdisciplinary team focusing on obesity management in adults.

KEY MESSAGE

There is a profound lack of interdisciplinary teams for obesity management in Canada.

NUMBER OF PHYSICIANS IN CANADA WITH CERTIFICATION FROM THE AMERICAN BOARD OF OBESITY MEDICINE



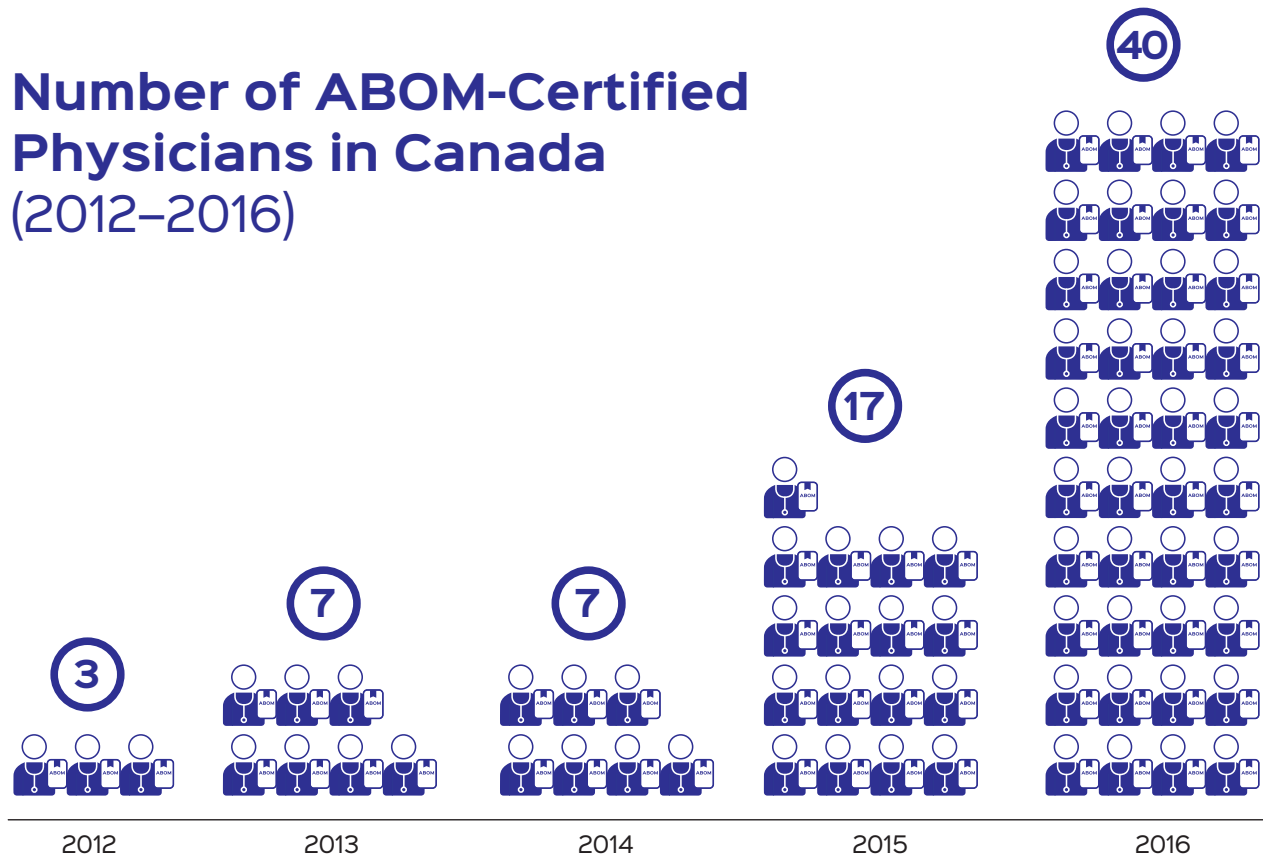
The Canadian Clinical Practice Guidelines⁹ recommend that continuing education activities that provide physicians and health professionals with the skills they need to counsel people confidently in healthy weight management should be developed.

The ABOM provides certification in managing obesity for physicians (including those in Canada) who pass the organization's examination. Certification as an ABOM diplomate signifies specialized knowledge in the practice of obesity medicine and distinguishes a physician as having achieved competency in obesity care. The first ABOM certification exams were offered in 2012.



- ➡ There are only 40 ABOM-certified physicians in Canada.
- ➡ Twenty-one of these physicians are in Ontario, eight in Alberta, six in British Columbia, two each in Nova Scotia and New Brunswick and one in Québec.
- ➡ There are no ABOM-certified physicians in the territories, Saskatchewan, Manitoba, Newfoundland and Labrador or Prince Edward Island.

NUMBER OF PHYSICIANS IN CANADA WITH CERTIFICATION FROM THE AMERICAN BOARD OF OBESITY MEDICINE



Source: ABOM.

KEY MESSAGE

While the number of ABOM-certified physicians in Canada has been rising, only a very limited number of Canadian physicians are pursuing formal training and certification in obesity management. There is a dire need for capacity building among health professionals to provide obesity care.

ACCESS TO MEDICALLY SUPERVISED WEIGHT-MANAGEMENT PROGRAMS WITH MEAL REPLACEMENTS



The Canadian Clinical Practice Guidelines⁹ recommend that meal replacement products and programs can be considered as a component of an energy-reducing diet for some adults interested in commencing a dietary weight-loss program.

Weight-management programs with meal replacement in Canada are comprehensive, behaviour-based, medically supervised programs that closely monitor and assess progress toward better health and well-being, in conjunction with comprehensive patient education and support.



- ➡ Meal replacements are used as part of medically managed weight-loss programs and are often used as a pre-surgical weight-loss tool for patients on the bariatric surgery route.
- ➡ The OPTIFAST® weight-management program is a one- to two-year medically supervised program that uses a 900-calorie meal replacement exclusively for 12 weeks and is delivered by an interdisciplinary healthcare team in defined clinics throughout Canada.
- ➡ The active weight-loss phase of the program consists of weekly group visits for 24 to 26 consecutive weeks, and the maintenance phase continues into the second year.
- ➡ Ontario Health Insurance Plan covers the costs associated with the medical supervision (diagnostic tests and clinicians). The cost of the meal replacements is an out-of-pocket expense for the patients.
- ➡ In Alberta, where weight-management programs with meal replacement are available, the provincial health authority covers the costs associated with the medical supervision (diagnostic tests and clinicians); however, the cost of the meal replacements is an out-of-pocket expense for the patients.

ACCESS TO MEDICALLY SUPERVISED WEIGHT-MANAGEMENT PROGRAMS WITH MEAL REPLACEMENTS



➡ Patients can be expected to pay between \$1,000 and \$2,000 for the meal-replacement portion of the OPTIFAST® weight-management program, depending on the length of the maintenance phase.

➡ The cost of meal replacements within weight-management programs is not covered by any provincial drug benefit program or private drug benefit plans. Such costs are considered an ineligible expense for health spending accounts with private drug benefit plans and are not an eligible expense in the medical expense tax credit offered by the Canada Revenue Agency.

KEY MESSAGE

Canadians who may benefit from medically supervised weight-management programs with meal replacements are expected to pay out-of-pocket for the meal replacements. *This is in sharp contrast with coverage available under provincial drug benefit programs for complete nutrition oral meal replacements for other chronic diseases, such as diabetes, cystic fibrosis and cancer.*

ACCESS TO PRESCRIPTION ANTI- OBESITY MEDICATIONS



The Canadian Clinical Practice Guidelines⁹ recommend the addition of a pharmacologic agent to assist in reducing obesity-related symptoms for some adults who are not attaining or who are unable to maintain clinically significant weight loss with dietary and exercise therapy alone. Pharmaceutical treatment of obesity is considered appropriate for adults with a BMI ≥ 30 kg/m² or a BMI ≥ 27 kg/m² in the presence of other risk factors (e.g., hypertension, diabetes, dyslipidemia or excess visceral fat).

Health Canada has approved two medications for the treatment of obesity in adults in Canada: orlistat 120 mg (Xenical®) and liraglutide 3.0 mg (Saxenda®). In the United States, the U.S. Food and Drug Administration currently approves five anti-obesity medications for long-term weight management: orlistat, lorcaserin, phentermine/topiramate, naltrexone/bupropion and liraglutide.^{26, 27}



Public Coverage

- ➡ Neither anti-obesity medication (Xenical® or Saxenda®) are listed as a benefit on any provincial/territorial formulary and, therefore, they are not covered under any provincial public drug benefit (or Pharmacare) programs.
- ➡ There may be special-access programs in some provinces that adjudicate coverage for non-formulary medications based on individual case review; however, coverage for anti-obesity medications through these programs are not guaranteed and are, in fact, rare.
- ➡ Anti-obesity medications are not covered in any Federal Public Drug Benefit Programs.

ACCESS TO PRESCRIPTION ANTI-OBESITY MEDICATIONS



➡ Xenical® is covered under the Canadian Forces Health Services Program (CFHSP) through an exception mechanism and Xenical® and Saxenda® are also covered under the Public Service Health Care Plan (PSHCP) without carrier approval. The CFHSP and PSHCP are private drug benefit plans that are available to federal public service employees. It is noteworthy that the federal government values the inclusion of anti-obesity medications to the benefits that are available to their employees.

➡ In contrast to coverage for anti-obesity medications, a 2016 report by the Canadian Diabetes Association showed that the provincial public drug benefit programs in all provinces and territories cover at least two medications for diabetes and in Ontario six medications for diabetes are covered.²⁸

Grading Access to Anti-Obesity Medications (Public Coverage)

Grading Criteria for the Public Coverage of Anti-Obesity Medications

Grade	Criteria
-------	----------



All Pharmacare programs cover both medications.



Both medications are covered by more than one of the Pharmacare programs.



At least one of the medications is covered by more than one of the Pharmacare programs.



At least one of the medications is covered by one of the Pharmacare programs.



No Pharmacare programs cover either medication.

Pharmacare Programs in All the Provinces and Territories



Federal Public Drug Benefit Programs



ACCESS TO PRESCRIPTION ANTI-OBESITY MEDICATIONS

Private Coverage

Around 60% of Canadians have private drug benefit plans, generally through employer-sponsored plans.²⁹ We invited 19 leading insurance companies (representing 99% of the health insurance industry in Canada) that offer private or employer-sponsored drug benefit plans to participate in a survey on the coverage for anti-obesity medications in their plans. Eleven insurers participated in the survey, revealing that:

- ➡ Only four of the 11 participating insurers recognize obesity as a chronic disease.
- ➡ Two participating insurers reported that they do not offer coverage for either anti-obesity medication in their private drug benefit plans.
- ➡ A majority of the participating health insurers reported that less than 10% of their private drug benefit plans offered any coverage for anti-obesity medications.
- ➡ Health spending accounts can be used to cover the costs of anti-obesity medications; however, a majority of the health insurers reported that less than 10% of their private plans offered such accounts.
- ➡ Nine out of 11 participating insurers indicated that plan sponsors (i.e., employers) could opt out of covering anti-obesity medications.

A customized report for coverage of anti-obesity medications in private drug benefit plans was produced by TELUS Health Analytics. The report was based on a sample that represents approximately 45% of lives – or 9,219,347 individuals – with access to private drug benefit plans that cover some costs of prescription medications in Canada. This report revealed that:

- ➡ Only 8.8% of individuals (815,848 individuals) in Canada within the sample of 9,219,347 individuals that have private drug benefit plans have access to anti-obesity medications through their plans.
- ➡ The number of individuals with coverage for anti-obesity medications through private drug benefit plans in each province and territory in a sample of 45% of individuals with private drug benefit plans in Canada is outlined on the next page.

ACCESS TO PRESCRIPTION ANTI-OBESITY MEDICATIONS

Number of Individuals (in a Sample of 45% of Individuals in Canada with Private Drug Benefit Plans) with Coverage for Anti-Obesity Medications

Province	Number of Individuals in the Sample	Number of Individuals with Coverage	Coverage Rate
Newfoundland and Labrador	164,041	3,657	2.2%
Prince Edward Island	40,103	448	1.1%
Nova Scotia	197,934	17,253	8.7%
New Brunswick	104,597	7,752	7.4%
Québec	1,366,831	103,231	7.6%
Ontario	4,280,852	416,269	9.7%
Manitoba	282,399	31,624	11.2%
Saskatchewan	441,045	57,475	13.0%
Alberta	1,309,237	122,680	9.4%
British Columbia	995,448	54,702	5.5%
Yukon	18,924	65	0.3%
Northwest Territories	6,666	658	9.9%
Nunavut	11,270	34	0.3%
Canada	9,219,347	815,848	8.8%

Source: TELUS Health Analytics Coverage Report (November 23, 2016).

The path to provincial formularies for any new medication is complex and involves a number of steps after receiving a Notice of Compliance from Health Canada. The lack of recognition of obesity as a chronic disease by provincial/territorial governments adds to the challenge for the inclusion of anti-obesity medications to public formularies.

Generally, health insurance companies that offer private drug benefit plans monitor the process and coverage status of a particular medication in the public domain, while conducting an independent review of the efficacy and cost-effectiveness of the medication before listing it on their formulary and offering it to their clients, i.e., employers that sponsor benefit plans for their employees. The insurer can cover the cost of any medication for which an employer negotiates coverage in the drug benefit plans they provide to their employees.³⁰ However, the pervasive notion of obesity as a lifestyle issue may have stalled employers' recognition that obesity is like any other chronic condition affecting the productivity and quality of life of their employees and deserving of medical treatment. Due to this gap in understanding the impact of obesity on their employees, a majority of Canadian employers have yet to make anti-obesity medications widely available through employer-sponsored drug benefit plans. The lack of recognition of obesity as a chronic disease by society as a whole has perpetuated the notion that it is a lifestyle issue and has also impacted the decisions made by employers for addressing obesity in their employees. Employers have invested in creating healthier workplaces by attempting to offer workplace gyms, weight-loss competitions and encouragement of healthy eating. However, these initiatives, although well intended rarely lead to long-term, sustainable weight management and are unlikely to meet the needs of people affected by obesity. Lack of participation in such programs is partly due to the pervasive social stigma that is associated

ACCESS TO PRESCRIPTION ANTI-OBESITY MEDICATIONS

with obesity and individuals' fear of public shaming. It would, therefore, be prudent to increase the awareness among Canadian employers of the impact of obesity on presenteeism and productivity of their employees, while simultaneously advocating for the recognition of obesity as a chronic disease to improve access to evidence-based treatments through employer-sponsored benefit plans.

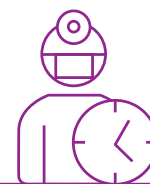
The TELUS Health Analytics Coverage Report finds that in a sample of 9.2 million Canadians with private drug benefit plans, only 8.8% of individuals, or 815,848 individuals, have plans that include coverage for anti-obesity medications. Publicly available information on the websites of Canadian insurers reveals that coverage in private drug benefit plans is greater for medications for other chronic diseases, like type 2 diabetes or hypertension. This is in sharp contrast to the coverage rate of anti-obesity medications in private drug benefit plans.

KEY MESSAGE

Estimating the national coverage for anti-obesity medications, it can be reasonably assumed that less than 20% of the Canadian

population with private drug benefit plans have access to these medications through these plans. Those who rely on public coverage for their prescription drug costs do not have access to these medications and are left paying for these medications themselves. Given the effectiveness of anti-obesity medications for long-term weight management,^{31, 32} it is unacceptable that Canadians have such limited access to these medications.

ACCESS TO BARIATRIC SURGERY



The Canadian Clinical Practice Guidelines⁹ recommend that adults with clinically severe obesity (BMI ≥ 40 kg/m² or ≥ 35 kg/m² with severe comorbid disease) may be considered for bariatric surgery when behavioural intervention is inadequate to achieve healthy weight goals.

Bariatric surgery is associated with immediate and long-term healthcare costs, but these are exceeded by expected benefits to the health of individuals with obesity, with the reduced onset of diabetes, remission of existing diabetes and lower mortality.³³

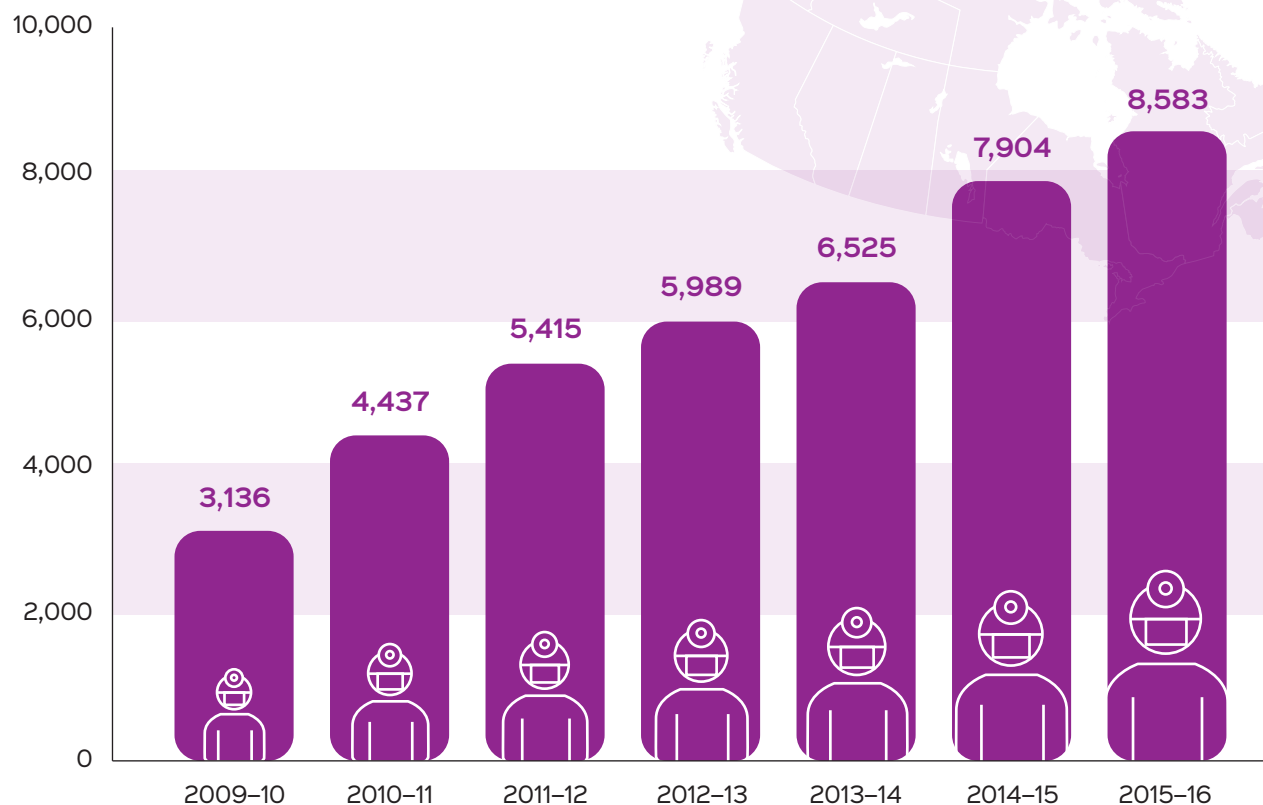


- ➡ Bariatric surgery is conducted in centres spread across nine provinces in Canada and is not conducted in the territories. There are 113 surgeons in 33 centres in Canada where bariatric surgeries are performed. The number of centres performing bariatric surgeries has not changed since an environmental scan conducted in 2012.³⁴
- ➡ Centres in many provinces do not accept out-of-province patients, which limits access to care for bariatric patients in provinces and territories with no surgical programs.
- ➡ Gastric bypass and sleeve gastrectomy are more commonly conducted procedures, and few provinces offer gastric banding.
- ➡ The number of bariatric surgeries in Canada continues to rise, though not at the pace at which the prevalence of Class II and Class III obesity rises.
- ➡ Bariatric surgery is available to one in 183 (or 0.54% of) adult Canadians per year who may be eligible for it, i.e., adults with Class II or Class III obesity.
- ➡ There is significant inequality in access to bariatric surgery in Canada. It can range from one in 90 adults in Québec with Class II or Class III obesity to one in 1,312 adults in Nova Scotia.

ACCESS TO BARIATRIC SURGERY

- ➡ Limited resources for bariatric surgery and an increasing number of referrals have led to unacceptable wait times.
- ➡ A significant proportion of the wait time experienced by patients referred to bariatric surgery is between referral and consultation with a specialist. Patients in most provinces wait for two years or more, and the wait can be as long as four to five years.
- ➡ Typically, wait times between consultation with a specialist and surgery is six to 12 months.
- ➡ Wait times can significantly vary from one province to the next.

Number of Bariatric Surgeries in Canada



Source: CIHI Report (December 2, 2016).

ACCESS TO BARIATRIC SURGERY

Number of Bariatric Surgeries in Canada (by Province) between 2009 and 2016

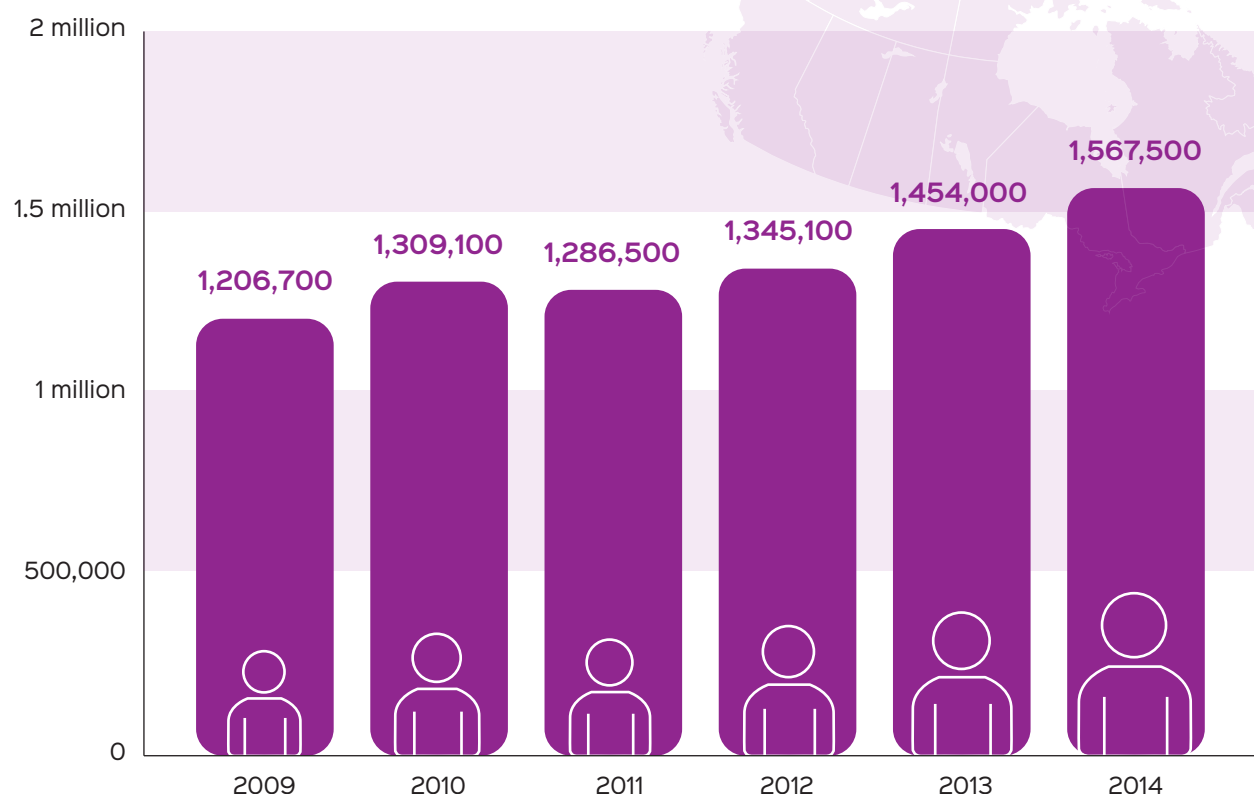
Province	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
Newfoundland and Labrador	0	0	38	84	108	104	101
Nova Scotia	59	61	51	62	62	47	51
New Brunswick	127	152	164	135	146	258	307
Québec	1,496	1,759	1,894	1,988	2,411	3,250 ^a	3,337 ^a
Ontario	932	1,855	2,511	2,846	2,833	3,063	3,503
Manitoba	0	41	89	104	123	134	197
Saskatchewan	47	62	81	78	90	111	82
Alberta	296	378	438	514	540	596	635
British Columbia	179	129	149	178	212	341	370
CANADA	3,136	4,437	5,415	5,989	6,525	7,904	8,583

Source: CIHI Report (December 2, 2016).

Footnotes:

^a This figure was reported in a personal communication with a policy maker in Québec. As part of the Agreement between the Government of Québec and CIHI, the data transmitted by Québec and held by CIHI may only be used for specific purposes. Therefore, CIHI was not authorized to provide us with the requested data.

Number of Adults in Canada with Class II or Class III Obesity



Source: Statistics Canada, CCHS, 2009–2014. Reproduced and distributed on an "as is" basis with permission of Statistics Canada.

ACCESS TO BARIATRIC SURGERY

Grading Access to Bariatric Surgery

Provinces/Territories	Adults who have Obesity (Class II or III - BMI: ≥ 35.00 kg/m ²) ^a	Number of Bariatric Surgeries in 2015–16 ^b	Number of Surgeries/ 1,000 Adults who have Class II or III Obesity	Access to Bariatric Surgery per year	Grade
Newfoundland and Labrador	39,400	101	2.56	1 in 390	F
Nova Scotia	66,900	51	0.76	1 in 1,312	F
New Brunswick	51,700	307	5.94	1 in 168	F
Québec	299,500	3,337 ^c	11.14	1 in 90	D
Ontario	624,600	3,503	5.61	1 in 178	F
Manitoba	66,700	197	2.95	1 in 339	F
Saskatchewan	66,100	82	1.24	1 in 806	F
Alberta	192,700	635	3.30	1 in 303	F
British Columbia	142,900	370	2.59	1 in 386	F
Prince Edward Island	9,700	Bariatric surgery is not performed			
Yukon	2,400	Bariatric surgery is not performed			
Northwest Territories	3,600	Bariatric surgery is not performed			
Nunavut	NA ^d	Bariatric surgery is not performed			
Canada	1,567,500	8,583	5.48	1 in 183	F

Footnotes:

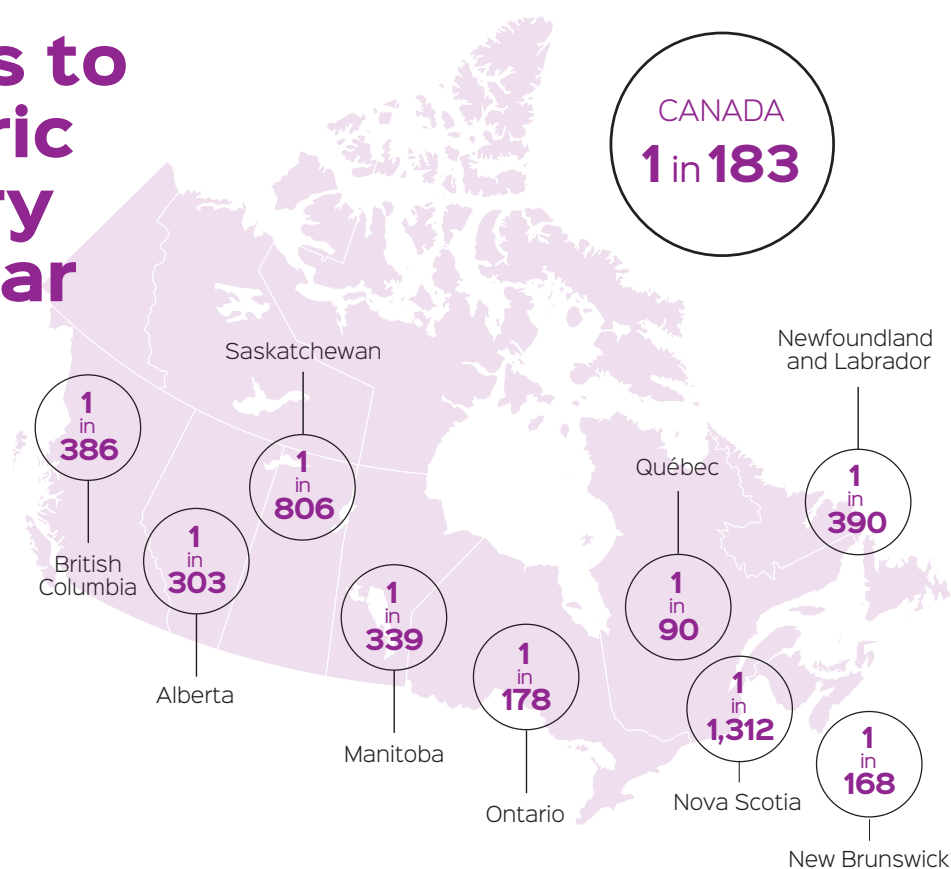
^a Source: Statistics Canada, CCHS, 2014. Respondents aged 18 and over excluding pregnant women. Reproduced and distributed on an "as is" basis with the permission of Statistics Canada.

^b Source: CIHI Report (December 2, 2016).

^c This figure was reported in a personal communication with a policy maker in Québec. As part of the Agreement between the Government of Québec and CIHI, the data transmitted by Québec and held by CIHI may only be used for specific purposes. Therefore, CIHI was not authorized to provide us with the requested data.

^d NA: Not available. Statistics Canada could not make this figure available as the coefficient of variation was greater than 33.3%, and it was deemed unreliable to report.

Access to Bariatric Surgery Per Year



Grading Access to Bariatric Surgery

Grading Criteria for Access to Bariatric Surgery

Grade Criteria

(A)	At least one in 10 adults who have Class II or Class III obesity have access to bariatric surgery.
(B)	At least one in 25 adults who have Class II or Class III obesity have access to bariatric surgery.
(C)	At least one in 50 adults who have Class II or Class III obesity have access to bariatric surgery.
(D)	At least one in 100 adults who have Class II or Class III obesity have access to bariatric surgery.
(F)	Less than one in 100 adults who have Class II or Class III obesity have access to bariatric surgery.

Access to Bariatric Surgery in All the Provinces except Québec

(F)

Access to Bariatric Surgery in Québec

(D)

Grading criteria for wait times between referral and consultation, and consultation and bariatric surgery were designed based on the benchmarks developed by the Wait Time Alliance on wait times for access to treatment for other conditions. Wait Time Alliance physicians have been developing benchmarks and targets to identify the longest medically acceptable amount of time that a patient should wait before receiving treatment. In their latest 2014 national report card on wait times,³⁵ the Wait Time Alliance proposed benchmarks for acceptable wait times for common conditions/procedures, such as arthritis care, cancer care, cardiac care, emergency rooms, general surgery, joint replacement, plastic surgery and others. Although they did not provide benchmarks for bariatric surgery, two of the specialty areas that share similarities in treatment are general surgery and joint replacement (due to it also being an elective procedure). The benchmark, i.e., the maximum acceptable wait time for a scheduled case of general surgery, is 16 weeks. A “scheduled case” was defined as a situation involving minimal pain, dysfunction or disability (also called “routine” or “elective”). In the field of joint replacement (hip and knee), the benchmark for consultation is three months and the benchmark for treatment (i.e., surgery) is within six months of consultation. Grading criteria and the grades are illustrated on the next page.

ACCESS TO BARIATRIC SURGERY

Grading Wait Times for Bariatric Surgery

Provinces	Waiting Time between Referral and Consultation	Grade	Waiting Time between Consultation and Surgery	Grade
Newfoundland and Labrador	24 months	F	12 months	C
Nova Scotia	60 months	F	Six months	B
New Brunswick	More than 36 months	F	12 months	C
Québec	24 months	F	Six to 12 months	B
Ontario	Referral to the Medical Program: up to 24 months	F	Six to 12 months	B
Manitoba	48 months	F	12 months	C
Saskatchewan	24 months	F	Six months	B
Alberta	18 to 24 months	F	More than 12 months	C
British Columbia	24 months	F	Six to 12 months	B

Wait Times for Bariatric Surgery

Grading Criteria for Wait Times for Bariatric Surgery

Grade Wait Time

	From Referral to Consultation	From Consultation to Surgery
(A)	Less than three months.	Less than six months.
(B)	Between three and six months.	Between six and 12 months.
(C)	Between six and nine months.	Between 12 and 18 months.
(D)	Between nine and 12 months.	Between 18 and 24 months.
(F)	More than 12 months.	More than 24 months.

Waiting Time between Referral and Consultation in All the Provinces

F

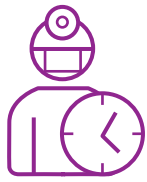
Waiting Time between Consultation and Surgery

NS, QC, ON,
SK, BC

NL, NB,
MB, AB

B

C



Wait times for bariatric surgery in Canada are the longest of any surgically treatable condition. It is noteworthy that there is a significant risk of patients dying while waiting for bariatric surgery.³⁶

KEY MESSAGE

With appropriate patient selection, education and follow up, bariatric surgery can offer sustainable weight loss (20% to 30%

reduction) with substantial reductions in morbidity and mortality (40% to 89% reduction^{36–40}) and marked improvements in mental health and quality of life.⁴¹ Not everyone who qualifies for bariatric surgery may be eligible for it and, as is the case with any surgery, bariatric surgery is also associated with some risks or complications. Complication rates associated with bariatric surgery are between 10% and 17%, reoperation rates are approximately 7% and the mortality rate is low (between 0.08% and 0.35%).⁴² According to latest estimates (2014), there are 1,567,500 adults in Canada who live with Class II or Class III obesity and may be eligible for bariatric surgery. Based on this information and the number of bariatric surgeries conducted in Canada in 2015–2016, it is evident that bariatric surgery is available to less than 0.54%, or one in 183, of adults per year who might stand to benefit from it. Despite relative increases in the number of surgeries performed, the current access to and wait times for bariatric surgeries in Canada is unacceptable.



Obesity has not received official recognition as a chronic disease by the federal government or any of the provincial/territorial governments, despite the Canadian Medical Association's recognition.

The lack of recognition of obesity as a chronic disease by public and private payers, health systems, the public and media has a trickle-down effect on access to treatment.

Obesity continues to be treated as a self-inflicted risk factor, which affects the type of interventions and approaches that are implemented by governments or covered by private health benefit plans.

There is no evidence of official guidelines or policies regarding obesity treatment and management for adults in any of the provinces or territories.

Some provincial and territorial governments are prioritizing obesity prevention efforts and promotion of healthy living initiatives.

Health promotion efforts in some provinces and territories are aimed primarily at children, youth or families.

Education on obesity management is often provided to patients as part of self-management programs (as for other chronic diseases, such as diabetes).

There is a profound lack on interdisciplinary teams for obesity management at the primary care level.

Access to exercise therapy and mental health support for obesity management is limited at the primary care level.

There are only 40 ABOM-certified physicians in Canada.

Patients are expected to cover the cost of meal replacements within medically supervised weight-management programs, which can be between \$1,000 and \$2,000. This is in contrast with coverage available under provincial drug benefit programs for complete nutrition oral meal replacements for other chronic diseases, such as diabetes, cystic fibrosis and cancer.

Anti-obesity medications are not covered by provincial public drug benefit programs or any of the Federal Public Drug Benefit Programs.

Coverage for anti-obesity medications through private drug benefit plans is available to less than 20% of individuals who have private drug benefit plans.

Bariatric surgery is available to one in 183 adults in Canada per year living with severe obesity.

Patients referred to bariatric surgery can experience wait times of up to five years before meeting a specialist or receiving the surgery.

Detailed information on study methodology and results – including ancillary findings that are not highlighted in this report – are available in the Appendix document.

*Report Card on Access to Obesity
Treatment for Adults in Canada 2017*

Recommendations

- 1** Provincial and territorial governments, employers and the health insurance industry should officially adopt the position of the Canadian Medical Association that obesity is a chronic disease and orient their approach/ resources accordingly.
- 2** Provincial and territorial governments should recognize that weight bias and stigma are barriers to helping people with obesity and enshrine rights in provincial/territorial human rights codes, workplace regulations, healthcare systems and education.
- 3** Employers should recognize and treat obesity as a chronic disease and provide coverage for evidence-based obesity programs and products for their employees through health benefit plans.
- 4** Provincial and territorial governments should increase training for health professionals on obesity management.
- 5** Provincial and territorial governments and health authorities should increase the availability of interdisciplinary teams and increase their capacity to provide evidence-based obesity management.
- 6** Provincial and territorial governments should include anti-obesity medications, weight-management programs with meal replacement and other evidence-based products and programs in their provincial drug benefit plans.
- 7** Existing Canadian Clinical Practice Guidelines for the management and treatment of obesity in adults should be updated to reflect advances in obesity management and treatment in order to support the development of programs and policies of federal, provincial and territorial governments, employers and the health insurance industry.

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